(2)

No. 90-640

In The

Supreme Court of the United States

October Term, 1990

MARY JANE WICKMAN,

Petitioner,

v.

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY,

Respondent.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

EDWARD S. ROONEY, Jr.*
LYNE, WOODWORTH & EVARTS
75 Federal Street
Boston, MA 02110
(617) 482-6655

**Counsel of Record*

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED FOR REVIEW

1. Whether petitioner's claim is governed by the Employee Retirement Income Security Act (ERISA) (29 U.S.C. §1001 et seq.)?

2. Whether the Court of Appeals misinterpreted federal common law under ERISA in affirming the District Court's conclusion that petitioner failed to carry her burden of proving that her husband's death was accidental?

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STATEMENT OF THE CASE

This action was commenced in the District Court for the District of Massachusetts by petitioner Mary Jane Wickman ("petitioner" or "Mrs. Wickman") seeking to recover the accidental death benefit under a group policy of insurance issued by respondent Northwestern National Life Insurance Company ("Northwestern") (Pet. App. A at 2a; Pet. App. B at 1b)[1]. The group policy covered Mrs. Wickman's late husband, Paul Wickman ("Mr. Wickman"), who died on July 11, 1984 (Pet. App. A at 2a, 4a). Originally commenced in federal court as a common law contract claim based on diversity of citizenship, the case was dismissed and the complaint amended so as to state a claim for benefits under section 1332 of the Employee Retirement Income Security Act (ERISA) (Pet. App. A at 7a). The parties agreed that there was no right to a jury trial in a claim for benefits under ERISA and consented to a trial before Magistrate Collings (Petition at 7; Pet. App. A at 7a).

After a four-day trial, where the evidence was considered on a *de novo* basis, the Magistrate concluded that Mrs. Wickman had not carried her burden of proving that Mr. Wickman's death was accidental (Pet. App. A at 7a; Pet. App. B at 5b, 12b-13b). Therefore, she was not entitled to recover accidental death benefits under Northwestern's group policy (Pet. App. B at 13b).

Mrs. Wickman appealed to the Court of Appeals for the First Circuit and challenged the Magistrate's ruling

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[1] References to "Pet. App." and "Resp. App." are to Petitioner's Appendix and Respondent's Appendix, respectively.

that her claim was governed by ERISA and his ultimate ruling that she had failed to prove that her husband's death was an accident so as to entitle her to benefits (Pet. App. A at 7a). The Court of Appeals, in a detailed and well-reasoned opinion, affirmed the Magistrate's rulings, holding that 1) Northwestern's group insurance benefits were part of an employee benefit plan provided by Mr. Wickman's employer and therefore were governed by ERISA (Pet. App. A at 11a-12a), and 2) the Magistrate applied a correct legal standard to the facts found in reaching his conclusion that Mr. Wickman's death was not an accident (Pet. App. A at 25a-27a). The former holding with respect to the applicability of ERISA was based primarily on the fact that Mr. Wickman's employer, Dexter Corporation, had provided its employees with a comprehensive benefit program, part of which was accidental death insurance, all as evidenced by Plaintiff's Exhibit 17, which clearly constituted an employee benefit plan under ERISA (Pet. App. A at 11a-12a; Resp. App. A). The Court of Appeals' holding with respect to the non-accidental character of Mr. Wickman's death was based on what the court determined to be the federal common law under ERISA with respect to accidental death insurance benefits (Pet. App. A at 13a). Applying this federal common law standard to the Magistrate's findings and rulings, the court concluded that the Magistrate did not commit any error of law in ruling that Mr. Wickman's death was not an accident in light of the facts found, which were not seriously disputed (Pet. App. A at 27a).

ARGUMENT

1. The District Court And Court Of Appeals Were Correct In Finding The Existence Of An ERISA Plan (Petition at 10-17).

As the Court of Appeals correctly stated, the question of whether an ERISA plan exists is "a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person" (Pet. App. A at 8a-9a, quoting from *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988), cert. denied, ___ U.S. ___, 109 S. Ct. 3216 (1989)). Both the Magistrate in the District Court and the Court of Appeals made detailed findings and well-reasoned rulings in reaching the conclusion that Mr. Wickman's employer had established an "employee welfare benefit plan" as defined by ERISA and therefore petitioner's claim for accidental death benefits under the plan was governed by ERISA (Pet. App. A at 8a-12a, Pet. App. C). Both the District Court and the Court of Appeals followed the analysis on this issue first developed in *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (en banc), and which continues to have widespread acceptance. See, *Hughes v. Blue Cross of No. California*, 215 Cal. App.3d 832, 854, 263 Cal. Rptr. 850, 863 (Cal. App. 1989), cert. denied, ___ U.S. ___, 110 S. Ct. 2200 (1990) ("*Donovan* adopted an analysis of the statutory language that enjoys widespread acceptance"). Their findings of fact are fully supported by the record, and most certainly are not clearly erroneous, and their conclusions are unassailable as a matter of law.

Petitioner's entire argument appears to be based on the premise that the mere purchase of group insurance by

an employer, and the annual payment of premiums thereon, is insufficient to establish an ERISA plan. Unfortunately, such a premise has nothing to do with the true facts of this case as established by the record. Most importantly, this premise totally disregards the fact that Mr. Wickman's employer, The Dexter Corporation, established a comprehensive benefit program for all its employees, of which the Northwestern National accidental death and dismemberment benefits (AD&D) were only one small part. As the Court of Appeals noted (Pet. App. A at 11a-12a), Dexter Corporation's purchase of this insurance was not an isolated incident but was part of a comprehensive benefit program as established by petitioner's own trial exhibit 17 (Resp. App. A attached)[2]. Petitioner's trial exhibit 17 (Resp. App. A), entitled "STATEMENT OF BENEFITS AND POLICIES" and prepared by The Dexter Corporation (Resp. App. A at 1a), contains a detailed description of all the benefits available to employees of The Dexter Corporation, including pension, insurance, profit-sharing, tuition assistance and savings plans (Resp. App. A at 21a-23a). Various types of insurance, including life, medical, dental and short and long term disability, were provided under the plan (Resp. App. A at 1a-10a). A "Summary Plan Description" of Northwestern's plan of insurance, including a "Statement of ERISA Rights" and a description of "Claim Procedures", all as required by 29 U.S.C. §1022, was included in the document (Resp. App. A at 17a-21a). Mr. Wickman,

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[2] Respondent's Appendix A includes only certain material sections of petitioner's trial exhibit 17. The complete document, which was introduced at trial, consists of 96 pages.

as a participant, was advised that this particular "plan of benefits" was administered by the Hysol Division of The Dexter Corporation (Resp. App. A at 17a) and that all claims for benefits would be processed by Northwestern (Resp. App. A at 18a). Mr. Wickman was further advised that he was "entitled to certain rights and protections under the Employee Retirement Security Act of 1974 (ERISA)" and he was then given a detailed description of those rights (Resp. App. A at 19a-21a). The "Claims Procedures" in the Summary Plan Description specifically set forth how a claim was to be filed and, if denied, how it could be appealed (Resp. App. A at 18a-19a). As the Court of Appeals indicated, this benefit program, of which Northwestern's accidental death insurance was a part, clearly showed that Dexter Corporation did more than simply purchase a group insurance policy and remit annual premiums (Pet. App. A at 11a-12a), as contended by petitioner.

This extensive benefit plan renders moot petitioner's contentions that there was little or no administrative responsibility on the part of the employer, Dexter Corporation, and therefore the safeguards of ERISA should not be invoked (Petition at 11-13). It also shows that petitioner's statements that "Northwestern never produced the written instrument required by 29 U.S.C. §1102 for creation of an "employer benefit plan" (Petition at 7-8) and "It is impossible to tell from the record whether or not Northwestern's insurance policy is even a part of an "employee welfare benefit plan" (Petition at 8) are patently false. In fact, these statements are directly contrary to statements made by petitioner in her Reply Brief to the

Court of Appeals. In her Reply Brief[3], petitioner unequivocally stated that "A review of Ex. 17 ["STATEMENT OF BENEFITS AND POLICIES"] *indicates that the Dexter Corporation did establish an ERISA plan;*" (Resp. App. B at 3b) (emphasis added), but went on to mistakenly conclude that "however, the life insurance policy purchased from Northwestern was not part of it" (Resp. App. B at 3b). While the specific page reference to the life insurance section of the plan was incorrect, as pointed out by petitioner, the fact remains that the Northwestern accidental death benefit was in fact a part of Dexter Corporation's benefit plan (Resp. App. A at 2a-7a, 17a-21a). Petitioner went on in her Reply Brief to concede that the Dexter plan "set forth a right of review, as is required by ERISA", citing 29 CFR §2560.503-1(g), with respect to the medical and dental benefits (Resp. App. B at 3b). Since the "right of review" with respect to Northwestern's life insurance (Resp. App. A at 18a-19a) is identical to the "right of review" with respect to medical and dental benefits (Resp. App. A at 13a-15a), petitioner would undoubtedly concede that the life insurance right of review also satisfies the procedural requirements of ERISA.

Since petitioner's entire argument on the non-applicability of ERISA is premised on a factually incorrect assumption, i.e. that the only evidence of Dexter Corporation's "plan" was the mere purchase of a group insurance policy, the entire argument is flawed. For the same reason, petitioner's reliance on *Fort Halifax Packing Co. v.*

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[3] Respondent's Appendix B consists of 3 pages from Petitioner's Reply Brief which are pertinent to the point under discussion.

Coyne, 482 U.S. 1, 107 S. Ct. 2211 (1987) is misplaced. In addition, the *Fort Halifax* case is distinguishable, as pointed out by the Magistrate (Pet. App. C at 10c-12c), in light of Justice Brennan's footnote 9 in which he contrasted the one-time severance payment mandated by Maine's statute to life insurance benefits paid to deceased employees' survivors on an ongoing basis. 107 S. Ct. at 2219. He noted that the latter situation requires an administrative scheme to process claims and pay out benefits, while the former situation did not since there were no ongoing benefits to be paid. *Id.* Thus, the *Fort Halifax* case supports the concept which was assumed in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549 (1987), that a group insurance policy issued to an employer, on which premiums are at least partially paid by the employer, can constitute the basis of an employee benefit plan under ERISA.

Petitioner appears to place great importance on certain evidence at trial from Northwestern's claim representative that she did not understand she was acting as a fiduciary and did not realize that petitioner's claim might be governed by ERISA (Petition at 7, 13-14). The Court of Appeals attached no significance to this and rightfully so. Whether Northwestern acted properly as a fiduciary or whether it complied with the administrative requirements of ERISA are irrelevant to the fundamental question of whether an employee benefit plan exists at all. This latter determination is made simply by applying the definition of "employee welfare benefit plan" in 29 U.S.C. §1002(1) to the facts of a particular case. *Donovan v.*

Dillingham, supra, 688 F.2d at 1370-1373. Once it is determined that ERISA applies to a "plan" because the statutory definition has been satisfied, the "Regulatory Provisions" in Subtitle B of ERISA, including "Reporting and Disclosure" (§§1021-1031), "Participation and Vesting" (§§1051-1061), "Funding" (§§1081-1086), "Fiduciary Responsibility" (§§1101-1114) and "Administration and Enforcement" (§§1131-1145), come into play. *Id.* at 1372. However, as the *Donovan* court stated, "clearly these are only the responsibilities of administrators and fiduciaries of plans covered by ERISA and *are not prerequisites to coverage under the Act" Id.* (emphasis added). ERISA coverage applies regardless of whether these several administrative responsibilities have been met. *Id. Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546, 551 (6th Cir. 1989), citing *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352, 1355 (9th Cir. 1984), cert. denied, 474 U.S. 865 (1985). See also, *Scott v. Gulf Oil Co.*, 754 F.2d 1499, 1503 (9th Cir. 1985). Thus, in the instant case, whether there was a written instrument as required by 29 U.S.C. §1102, or whether there was compliance with 29 U.S.C. §1133 (Petition at 7-8), or whether Northwestern acted properly as a fiduciary as required by 29 U.S.C. §1104 (Petition at 13-14), are entirely irrelevant to the question of whether an ERISA plan exists in the first instance.

Petitioner's contentions with respect to the applicability of ERISA to this case have been fully considered and correctly decided by both the District Court and the Court of Appeals. There are clearly no special or important reasons, nor any split of authorities, which would justify granting a writ of certiorari to further consider these contentions.

2. The Court Of Appeals Did Not Create A Never-Never-Land Between Suicide And Accident (Petition at 18-21).

Neither the Magistrate nor the Court of Appeals left any doubt that their ultimate finding in the case was that Mr. Wickman's death was not the result of an accident. Since this finding was entirely determinative of Mrs. Wickman's claim for *accidental death* benefits, there was obviously no need to go any further and make additional findings with respect to the issue of suicide. Thus, the petitioner is completely in error when she argues that some "Never-Never Land" was created.

The Magistrate specifically found that "the plaintiff has not carried her burden, i.e. demonstrated by a preponderance of the evidence that Mr. Wickman's death was accidental within the meaning of the insurance policy" (Pet. App. B at 5b; also see Pet. App. B at 11b, 13b). The Court of Appeals affirmed this ruling, holding that "we believe that the magistrate did not err in ruling that Wickman's death was not an accident within the terms of the insurance policy" (Pet. App. A at 25a). The Court of Appeals went on in a footnote to dispose of petitioner's present contention: "Because the magistrate decided there was no accident in this case, and we affirm on this basis, he did not and we need not reach the question of whether Wickman's death was actually a suicide" (Pet. App. A at 25a, n. 5). The rulings of both the Magistrate and the Court of Appeals on this point couldn't be any clearer or any more determinative of petitioner's claim.

3. In Raising The Presumption Against Suicide And The Prima Facie Effect Of The Death Certificate, Petitioner Is Arguing The Weight Of The Evidence (Petition at 22-26).

Since this case was tried to the Magistrate without a jury (Pet. App. B at 2b, 14b), the Magistrate's findings must be accepted unless clearly erroneous. Fed. R. Civ. P. 52(a). Petitioner is not directly challenging the Magistrate's findings as clearly erroneous, but she is challenging them indirectly by arguing that some weight, or greater weight, should have been accorded the presumption against suicide and the prima facie effect of Mr. Wickman's death certificate. Petitioner argues that these presumptions should both have been operative in this case with the result that she presented a prima facie case of accidental death (Petition at 25). However, such a contention is meaningless in light of the fact that there was abundant, real evidence, not presumptions, from several live witnesses who had personal knowledge of the facts and circumstances surrounding Mr. Wickman's death (Pet. App. A at 2a-5a; Pet. App. B at 7b-9b). Obviously, the Magistrate had no need to resort to evidentiary presumptions since there was clear and convincing real evidence on the issue of accident. Moreover, the presumption against suicide is merely a rebuttable presumption of fact which stands until rebutted by other evidence. *Bohaker v. Travelers Insurance Co.*, 215 Mass. 32, 36, 102 N.E. 342, 344 (1913). Under Massachusetts law, which petitioner concedes is the law applicable to these presumptions (Petition at 22), the presumption against suicide disappears once contrary evidence is introduced. Liacos, Handbook of Massachusetts Evidence, 54 (1981).

The cases cited by petitioner on this issue from other jurisdictions are not controlling because in those cases the presumption against suicide had the weight of affirmative evidence and the presumption did not disappear once contrary evidence was presented. *Dick v. New York Life Ins. Co.*, 359 U.S. 437, 442-444, 79 S. Ct. 921, 925 (1959) (applying North Dakota law). *Canada Life Assurance Co. v. Houston*, 241 F.2d 523, 531-532 (9th Cir. 1957) (applying California law). This is simply not the law on presumptions in Massachusetts.

Furthermore, the "prima facie" effect of the "facts recorded" in the amended death certificate – "Massive internal hemorrhage secondary to fracture – dislocation of pelvis – caused by 90 foot fall from bridge" (Petition at 23-24) – is inconclusive on the issue of whether death was accidental. There is nothing in the death certificate stating whether death was accidental or not, and the foregoing statement of facts as to the *cause* of the death leaves it entirely to conjecture as to whether the *manner* of death was accidental. Again, the Magistrate obviously felt no need to resort to such inconclusive information when there was real evidence which was much more helpful on the issue of whether death was accidental.

The bottom line is that petitioner is indirectly contending that the Magistrate's factual findings are wrong (she never uses the phrase "clearly erroneous") because he didn't place greater weight on the foregoing presumptions. Not only does this contention employ an improper standard for reviewing factual findings of a lower court, it is a contention which has no place under this Court's standards of review on a petition for certiorari. Rules of the Supreme Court, Rule 10.

4. The Court Of Appeals Test For Considering Accidental Death Cases Under ERISA Federal Common Law Is Legally Sound And In Accordance With Common Law Precedents (Petition at 18-21, 26-29).

Contrary to petitioner's contentions, the Court of Appeals approach to analyzing accidental death cases such as this will not "plunge the federal common law into a 'Serbonian bog' " (Petition at 29). Nor will application of this approach result in the denial of millions of dollars in accidental death benefits (Petition at 18). Such contentions evidence a complete lack of understanding by petitioner of the test formulated by the Court of Appeals. Quite to the contrary, this test provides a practical and easily applied formula for the factfinder to use which is fully supported by the many state and federal common law cases which have struggled with the concept of accidental death.

The Court of Appeals correctly rejected the outdated distinction between "accidental means" and "accidental results" as being artificial and confusing[4] (Pet. App. A at 17a-20a). After concluding that definitions of the term "accident" are not helpful, since the term is largely intuitive (Pet. App. A at 20a-21a), the Court went on to devise the following analysis for use in accidental death cases. The factfinder must first determine whether the result which occurred was within the "reasonable expectations

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[4] Northwestern has always accepted the policy language as creating "accidental results" coverage rather than "accidental means" coverage. The Magistrate's opinion clearly shows that he did not use, nor even consider, an "accidental means" standard in analyzing the case (Pet. App. B at 9b-10b).

of the insured." If it was, then there can be no accident. If it wasn't, then the factfinder must consider whether the insured's reasonable expectations were "patently unreasonable." If they were, as in the case of "Russian roulette", then again there can be no accident. If the factfinder is unable to determine the subjective expectations of the insured, then it should consider the objective expectations of a "reasonable person" standing in the shoes of the insured. The core concepts of this analysis are that the issue of accidental death is almost always one of fact and the determination is to be made from the subjective perspective of the insured.

None of the cases cited by petitioner are inconsistent with the foregoing formula. In fact, mostly all of them endorse, although in somewhat different terms, the approach promulgated by the Court of Appeals. For example, in *Collins v. Nationwide Life Ins. Co.*, 294 N.W.2d 194 (Mich. 1980) (Petition at 26-27), the Michigan Supreme Court expressly endorsed the concept of the insured's foreseeable expectations as the appropriate standard and rejected the use of the tort concept of reasonable foreseeability. *Id.* at 196. (Insured died from acute alcoholic intoxication). In *Catania v. State Farm Life Ins. Co.*, 598 P.2d 631 (Nev. 1979) (Petition at 27), the Nevada Supreme Court adopted the reasoning of *Knight v. Metropolitan Life Ins. Co.*, 103 Ariz. 100, 437 P.2d 416 (1968) and *Miller v. Continental Ins. Co.*, 40 N.Y.2d 675, 389 N.Y.S.2d 565, 358 N.E.2d 258 (1976) in approaching the issue from the point of view of the insured, not the "reasonable man", and whether from the insured's point of view the result was "unexpected, unusual and unforeseen." *Miller* case, *supra*, 40 N.Y.2d at 677. To the same effect are

Kearbey v. Reliable Life Ins. Co., 526 S.W.2d 866 (Mo. App. 1975) (Petition at 27-28), *Sivley v. American National Ins. Co.*, 454 S.W.2d 799 (Tex. App. 1970) (Petition at 29) and *Russell v. Metropolitan Life Ins. Co.*, 439 N.E.2d 89 (Ill. App. 1982) (Petition at 29), all of which adopt a subjective test of foreseeability. There is no doubt that the results in all of these cases would have been the same if the Court of Appeals approach had been used.

The Court of Appeals approach is not at all different from the prevailing common law approach, see 10 Couch on Insurance 2d, §41:7 at 9 ("An accident [is anything] . . . that takes place without the insured's foresight or expectation . . . . "), and §§41:15, 41:17, 41:23, 41:25; 1A Appleman, Insurance Law and Practice, §360 (at 452-453: "In construing whether or not a certain result is accidental, it is customary to look at the casualty from the point of view of the insured, to see whether or not, from his point of view, it was unexpected, unusual and unforeseen."). It merely clarifies the application of this approach in accidental death cases. For example, the Court's requirement that the insured's expectations not be "patently unreasonable" (Pet. App. A at 22a-24a) in order for the death to be accidental is entirely consistent with the results reached in Russian roulette cases and autoerotic asphyxiation cases (Pet. App. A at 22a-23a; Pet. App. B at 13b). In each of these types of cases, courts generally conclude that the insured's expectation that he will not die as a result of his voluntary conduct is so patently unreasonable that the resulting death cannot be deemed an accident. See, *Nicholas v. Provident Life & Acc. Ins. Co.*, 61 Tenn. App. 633, 457 S.W.2d 536 (1970) (Russian roulette) and *Runge v. Metropolitan Life Ins. Co.*, 537 F.2d 1157

(4th Cir. 1976) (autoerotic asphyxiation). *But see, Kennedy v. Washington National Ins. Co.*, 401 N.W.2d 842 (Wis. App. 1987) (Death from autoerotic asphyxiation is not highly probable or likely to occur and therefore differs from Russian roulette). On the other hand, an insured's death from an overdose of drugs or alcohol is generally considered to be accidental because death as a result of taking drugs is not deemed to be "highly probable". See, *Hardy v. Beneficial Life Ins. Co.*, 787 P.2d 1 (Utah App. 1990) (Defendant failed to establish the "high level of certainty" that death or injury would result from insured's consumption of drugs).

As the Court of Appeals noted (Pet. App. A at 26a-27a), the Magistrate specifically found that Mr. Wickman's actions in climbing over the guardrail and hanging by one hand were intentional and knowing and that it was reasonably foreseeable to him that death or serious bodily injury was substantially likely to occur (Pet. App. B at 11b, 12b-13b). Under any test or formulation that has yet been articulated, these factual findings mandate the conclusion that Mr. Wickman's resulting death was not accidental. The Magistrate further found that, unlike the numerous cases cited by petitioner (Petition at 26-29), "[T]his is not a case wherein the insured intentionally did an act with some unexpected result" (Pet. App. B at 11b). Thus, the several cases cited by petitioner, most of which involve death as a result of an overdose of drugs or alcohol, are inapposite. Again, with these underlying factual findings of Mr. Wickman's intent and knowledge, no other conclusion could be reached than that Mr. Wickman's death was not accidental.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

NORTHWESTERN NATIONAL LIFE
INSURANCE COMPANY
By their attorneys,
EDWARD S. ROONEY, Jr.*
LYNE, WOODWORTH & EVARTS
75 Federal Street
Boston, MA 02110
(617) 482-6655
**Counsel of Record*

DEXTER LOGO

HYSOL DIVISION
THE DEXTER CORPORATION

STATEMENT
OF
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DENTAL COVERAGE

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LIFE INSURANCE

Northwestern National Life Insurance Company
Minneapolis, Minnesota 55440

We, Northwestern National Life Insurance Company, certify that we have issued the Group Policy(ies) listed below to the Policyholder. All benefits are controlled by the terms and conditions of the Group Policy(ies).

The Group Policy(ies) are on file in the Policyholder's office. You may look at the Group Policy(ies) there.

Group Policy Number	Policyholder
GL-18090-4	The Dexter Corporation

Your beneficiary is the last beneficiary you named, according to the records on file in our Home Office. You may change your beneficiary any time, according to the terms of the Group Policy.

The Policyholder must provide to you a 15 day written notice if and when the Group Policy is cancelled or substituted.

This certificate summarizes and explains the parts of the Group Policy which apply to you. This certificate is not an insurance policy. In any cases of differences or errors, the Group Policy rules.

This certificate replaces any other certificates we may have given you under the Group Policy.

/s/ Gretchen A. Larson
Registrar

LIFE INSURANCE

Schedule of Benefits

BASIC LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Class	Amount of Life Insurance	Full Amount of AD&D Insurance
Exempt employees whose Basic Yearly Earnings* are ___		
$10,000 but less than $12,500	$15,000	$15,000
$12,500 but less than $15,000	$17,500	$17,500
$15,000 but less than $17,500	$20,000	$20,000
$17,500 but less than $20,000	$22,500	$22,500
$20,000 but less than $22,500	$25,000	$25,000
$22,500 but less than $25,000	$30,000	$30,000
$25,000 but less than $27,500	$35,000	$35,000
$27,500 but less than $30,000	$40,000	$40,000
$30,000 but less than $32,500	$45,000	$45,000
$32,500 but less than $35,000	$50,000	$50,000
$35,000 but less than $40,000	$55,000	$55,000
$40,000 but less than $45,000	$65,000	$65,000
$45,000 but less than $50,000	$75,000	$75,000
$50,000 but less than $55,000	$85,000	$85,000
$55,000 but less than $60,000	$95,000	$95,000
$60,000 and over	$105,000	$105,000
Retired exempt employees	$2,500	none

* * *

LIFE INSURANCE

AD&D Insurance

What is the Accidental Death and Dismemberment (AD&D) Insurance Benefit?

We pay AD&D benefits if you lose your life, limb, or sight due to accidental injury.

Under what conditions do we pay benefits?

We pay benefits if all of the following are true:

- You are covered for AD&D Insurance on the date of the accident.
- Loss occurs within 180 days of the accident.
- The cause of the loss is not excluded.

How much will we pay?

We pay the benefit shown on the Table of AD&D Benefits if you suffer any of the losses listed. The Full Amount of AD&D Insurance is shown in the Schedule of Benefits. We pay only one Full Amount for any one accident.

Table of AD&D Benefits

For loss of:	The benefit is:
Life	Full Amount
Both hands	Full Amount
Both feet	Full Amount
Sight of both eyes	Full Amount
1 hand and 1 foot	Full Amount
1 hand and sight of 1 eye	Full Amount
1 foot and sight of 1 eye	Full Amount
1 hand	1/2 Full Amount
1 foot	1/2 Full Amount
Sight of 1 eye	1/2 Full Amount

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight.

We do not pay a benefit for loss of use of the hand or foot.

To whom do we pay benefits?

We pay death benefits to your beneficiary. We pay any other benefits to you.

When don't we pay benefits?

We do not pay benefits for loss directly or indirectly caused by any of these:

- Suicide or intentionally self-inflicted injury, whether you are sane or insane.
- Physical or mental illness.
- Bacterial infection or poisoning. **Exception:** Infection from a cut or wound caused by an accident is covered.
- Riding in or descending from an aircraft as a pilot or crew member.
- An act of war.
- Injury suffered while in the military service for any country.

  "War" is any armed conflict, whether declared as war or not, involving a country. **"Country"** is any government or group of countries. **"Military service"** means service in any army, navy, air force, marines, coast guard, or any branch of the military.
- Injury which occurs during a crime you commit or try to commit.

How do you submit a claim?

Step. 1.

Written notice of claim must be sent to us within 20 days of your death or dismemberment, or as soon as possible. We will send you forms for filing proof of loss within 15 days after receiving the notice of claim.

Step. 2.

Written proof of loss must be sent to us within 90 days of your death or dismemberment, or as soon as possible. Written proof includes details about the loss and how it happened. Proof of loss must be sent in the required time even if proof of loss forms are not received.

We may, at our expense, require an exam while considering your claim. If you die, we may require an autopsy where law permits.

* * *

INTRODUCTION

If you are ill or injured and cannot work for a short period of time, it's comforting to know that the Hysol Division provides benefits to protect you against loss of income. These temporary disability benefits are provided under the Short Term Disability Income Benefits Plan. Your benefits begin as soon as you are disabled and pay you up to 100% of your base salary for up to six months, depending upon your length of service.

The full cost of these temporary disability benefits is paid for by the Company.

The remainder of this summary explains your temporary disability benefits in more detail.

SHORT TERM DISABILITY INCOME BENEFITS

If your non-work-related illness or injury takes you away from work, you will be eligible for Short Term Disability (STD) Income Benefits. Workers' Compensation will cover work-related illness or injury.

As soon as you are disabled, you will begin receiving Company benefits. The table below outlines those benefits, based on your length of service.

IF you have . . .	THEN you will receive . . .	FOR . . .
less that 1 year of continuous service	50% of your base salary	up to 6 months
1-6 years of continuous service	1) 1 month's full base salary for each year of continuous service, **then** 2) 50% of your base salary for the remaining months	up to 6 months
more than 6 years of continuous service	your full monthly base salary	the first 6 months of your disability

For example, if you

- have worked 4 years,
- earn a monthly salary of $1,500, and
- are disabled for 5 months

. . . you will receive total benefits of $6,750: (4 months x $1,500/month + (1 month x $1,500/month x .5) = $6,750.

In order to receive the STD benefits, you may be asked to show medical proof of disability (e.g. doctor's written statement) in order for benefits to be paid or continued.

* * *

Who Is Eligible

As a full-time employee, working at least 30 hours per week, you automatically participate in the Long Term Disability (LTD) Insurance Plan, providing:

- you have completed 12 months of continuous employment, and
- you have not reached the age of 69 years and 6 months

COST

The Company pays the full cost of your LTD coverage.

SUMMARY OF BENEFITS

If you become totally disabled as a result of an illness, injury or pregnancy for at least six consecutive months, LTD benefits will provide monthly income to you.

Amount of Monthly Benefit

Your monthly benefit is the Schedule Amount reduced by the Offset Amount. In no event will your monthly benefit exceed the Monthly Payment Limit.

The Schedule Amount is an amount equal to

- 50% of your monthly earnings

  up to a

- maximum schedule amount of $3,500.

The Offset Amount consists of the following payments and benefits for your disability from the following sources. These payments and benefits are subtracted directly from the schedule amount of benefit.

- retirement benefits provided under any formal or informal plan or arrangement contributed directly or indirectly by The Dexter Corporation or through payroll deductions or under Social Security.

- periodic benefits for lost income provided under or by (i) any group, franchise or wholesale insurance contract or any other benefit plan or arrangement for which The Dexter corporation has made payroll deductions or contributed (directly or indirectly) to the cost, (ii) any Workers' Compensation Act, non-occupational disability benefits law or similar legislation.

- periodic cash payments (including dependent's benefits, if any) provided under or by Social Security or any other law of the United States, Canada or any state or political subdivision thereof.

* * *

Who is Eligible

The Pension Plan covers all full-time employees of the Hysol Division except union employees who have not bargained for coverage under the Plan.

You automatically become a member on January 1 or July 1 following your completion of one year of service, provided you are at least age 25 and under age 60.

The Pension Plan may also cover you if you are a part-time employee. As a part-timer, you become a member at the same time as a full-time employee if you work 1,000 hours during your first 12 months of work. Otherwise, you become a Plan member on January 1 or July 1 following the end of any subsequent anniversary year in which you do work 1,000 hours. (Your anniversary year begins on the day you were hired and ends 12 months later.) For example, if you were hired on April 1, 1978, your anniversary year would be April 1 to March 31. If you worked 850 hours by March 31, 1979, you would not be eligible for the Plan. However, if between April 1, 1979 and March 31, 1980 you worked at least 1,000 hours, your membership would be effective July 1, 1980.

YOUR COMPANY SERVICE

Your service with the Company is important under this Plan because it affects **when** you receive Plan income and **how much** that income will be.

There are two types of service under this Plan, "Vesting Service" and "Credited Service". Vesting Service determines when you become eligible for benefits, and Credited Service determines how large your benefits will be. Each of these terms will be defined in more detail as they arise in this summary.

WHEN YOU CAN RETIRE

- **Normal Retirement** – Your Normal Retirement date is the first of the month following your 65th birthday. Although this is the traditional retirement age in the U.S., you may retire earlier or later than this age.

- **Early Retirement** – Upon reaching age 55, you may retire the first of any month after that provided you have at least 10 years of Vesting Service.

- **Deferred Retirement** – If you want, you may work beyond age 65 as long as you continue to perform your job well.

* * *

SUMMARY PLAN DESCRIPTION FOR A PLAN OF BENEFITS ADMINISTERED BY

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY MINNEAPOLIS, MINNESOTA 55440

Plan Name, and Name and Address of Planholder:

The Dexter Group Medical and Dental Coverage Plan
The Dexter Corporation
One Elm Street
Windsor Locks, Connecticut 06096

Name, Address, and Telephone Number of the Plan Administrator:

Hysol Division
The Dexter Corporation
15051 East Don Julian Road
Industry, California 91749
(818) 968-6511

Employer Identification Numbers

IRS Employer Identification Number: 060321410
Plan Number: 501

Agent for Legal Process:

Same as Plan Administrator

Trustees: None

Type of Administration:

Records maintained by the Employer

Contribution Payments:

Employee and Employer contribute

Plan Year:

January 1 through December 31

Claim Procedures: Please refer to the CLAIM PROCEDURES PAGE.

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS page.

Eligibility and Circumstances Limiting Eligibility:

As described in the Employee Booklet.

Type of Plan:

As described in the Employee Booklet.

Benefits in Plan:

See Employee's Coverage and Dependents' Coverage in Employee Booklet.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES

1. Claim forms may be obtained from the Plan Administrator or Personnel Department.

2. Northwestern National Life Insurance Company (we) will process the claim and make payment or issue a denial notice.

3. Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. If no notice is received during that period then the claimant can assume the claim was denied and request a review of the denial. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.

4. The notice of denial will be written in an understandable manner and include the following:

   (a) The specific reason(s) for the denial;

   (b) Specific reference to the provision which forms the basis of the denial;

   (c) A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed; and

   (d) An explanation of our claim review procedure.

5. The claimant may request an appeal at any time during the 60 day period following receipt of the notice of denial of the claim.

6. We will consider requests for an appeal of a denied claim upon written application of the claimant or his duly authorized representative. The claimant may, in the course of this appeal, review pertinent documents and submit to us a statement of issues and comments in writing.

7. We will provide the claimant with a written decision providing the final determination of the claim. This decision will be written in an understandable way,

will state the specific reason(s) for the decision and will make specific reference to the provision on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, and usually within 60 days. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary.

SUMMARY PLAN DESCRIPTION
STATEMENT OF ERISA RIGHTS

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's Annual Financial Report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people

who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these cost and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions

about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

SUMMARY PLAN DESCRIPTION FOR A PLAN OF INSURANCE UNDERWRITTEN BY

Northwestern National Life Insurance Company Minneapolis, Minnesota 55440

Plan Name, and Name and Address of Policyholder:

The Dexter Group Insurance Plan
The Dexter Corporation
One Elm Street
Windsor Locks, Connecticut 06096

Name, Address, and Telephone Number of the Plan Administrator:

Hysol Division
The Dexter Corporation
15051 East Don Julian Road
Industry, California 91749
(818) 968-6511

Policyholder Identification Numbers

IRS Employer Identification Number: 060321410
Plan Number: 501

Agent for Legal Process:

Same as Administrator

Trustees: None

Type of Administration:

Records maintained by Policyholder

Premium Payments:

Employee and Employer contribute

Plan Year:

January 1 through December 31

Claim Procedures: Please refer to CLAIMS PROCEDURES page.

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS page.

Eligibility and Circumstances Limiting Eligibility:

See Employee's Insurance in Certificate of Insurance.

Type of Plan:

As described in the Certificate of Insurance.

Benefits in Plan:

See Employee's Insurance in Certificate of Insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES

1. Claim forms may be obtained from the Plan Administrator or Personnel Department.
2. Northwestern National Life Insurance Company (we) will process the claim and make payment or issue a denial notice.
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4. The notice of denial will be written in an understandable manner and include the following:

   (a) The specific reason(s) for the denial.
   (b) Specific reference to the provision which forms the basis of the denial.
   (c) A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   (d) An explanation of our claim review procedure.

5. The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.

6. We will consider requests for an appeal of a denied claim upon written application of the claimant or his duly authorized representative. The claimant may, in the course of this appeal, review pertinent documents and submit to us a statement of issues and comments in writing.

7. We will provide the claimant with a written decision providing the final determination of the claim. This decision will be written in an understandable way, will state the specific reason(s) for the decision, and will make specific reference to the provision on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, and usually within 60 days. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if its extension is necessary.

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STATEMENT OF ERISA RIGHTS

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Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

> Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
>
> Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
>
> Receive a summary of the plan's Annual Financial Report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants. ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you

may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. if you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

EMPLOYEE BENEFITS

CASH BONUS/PROFIT SHARING

We've always believed our employees should share in the company's growth. That's why we have a cash bonus/profit sharing plan for our exempt employees. The Human Resources department will explain the particulars to you.

PENSION, GROUP LIFE INS., LONG TERM DISABILITY, COMPREHENSIVE MEDICAL BENEFITS, BUSINESS TRAVEL

Details of these plans are listed separately in your personal benefits handbook.

WORKMEN'S COMPENSATION

Of course, you are also entitled to benefits under Workmen's Compensation laws in the state where you work if you are injured on the job. These benefits cover time away from work and medical expenses.

TUITION REFUND

Many of our employees take high school, college or professional courses in their spare time to improve their job performance and advancement opportunities. We not only encourage this but also provide financial assistance in the form of our educational refund plan. To get all the facts on this program, check with your supervisor or the Human Resources department.

EMPLOYEE STOCK PURCHASE PLAN

Here's another way you can share in the company's growth – by becoming a part owner of The Dexter Corporation. Under payroll investment plan, regular deductions are made to purchase shares of the corporation's stock. You can get all the details of this program from the Payroll Investment Plan manual.

SAVINGS PLANS

We have payroll deduction plans for Christmas Club savings and for purchasing U.S. Government Bonds. The Human Resources department has all the details.

CREDIT UNION

Membership in the Hysol Division, The Dexter Corporation Federal Credit Union is available. The Company participates by making authorized payroll deductions for savings and loans, and provides office space. The Credit Union is an independent organization chartered by the federal government for Hysol people who elect their own officers.

SERVICE AWARDS

We want you to stay and grow with the company. As a symbol of continuous service to you and your fellow employees. The Dexter Corporation is proud to recognize length of service through presentation of service awards at each five year interval of service.

* * *

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

NO. 89-2030

MARY JANE WICKMAN,
Plaintiff-Appellant

V.

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY,
Defendant-Appellee

REPLY BRIEF OF PLAINTIFF-APPELLANT

Richard L. Neumeier
PARKER, COULTER, DALEY & WHITE
One Beacon Street
Boston, MA 02108
(617) 723-4500

* * *

II. In The Alternative, The Magistrate Erred In Ruling That The Northwestern Policy Constituted A Claim Within The Meaning Of ERISA.

A. On this point Northwestern begins with the incredible assertion that this court's review of the allowance of its motion to dismiss is governed by the clearly erroneous standard(!). (appellee's brief at 14). No case is cited for this remarkable proposition. Since Northwestern was seeking the benefit of the ERISA preemption, the burden was upon it to establish the existence of the plan as Mary Jane noted in her initial brief. (appellant's brief at 32).

Northwestern plays lip service to the proposition that the mere purchase of an insurance policy does not establish a claim within ERISA. (appellee's brief, 15, 16). In addition to the fact that there were periodic premium payments, Northwestern asserts that a plan was established because

> " . . . the allegations . . . reflected that Mrs. Wickman knew that she was an intended beneficiary who was fully aware of the procedure for applying for such benefits. (A. 110-111)." (appellee's brief at 16).

It would be a strange life insurance policy that did not articulate a procedure for the beneficiary to apply for benefits. This court can take judicial notice of the fact that life insurance policies for generations have contained standard provisions setting forth "the procedure for applying for" benefits. The existence of such a procedure is insufficient to establish a "plan" within the meaning of ERISA.

C. Finally, Northwestern argues that there was no harmful error because at trial there was introduced into evidence a document entitled "STATEMENT OF BENEFITS AND POLICIES" prepared by the Dexter Corporation (Dexter). (E. 37) (appellee's brief at 16). Northwestern points out that this STATEMENT contains a detailed description of benefits available to Dexter Corporation employees and then asserts:

> "The life insurance benefits provided by Northwestern were described in an easy-to-read question and answer format. (E. 57-63). A 'summary plan description' of these benefits, including a 'statement of ERISA rights' and a description of 'claim procedures', all is required by 29 U.S.C.

§ 1022, was included in this document. (E. 82-83a)." (appellee's brief, 16, 17).

A review of Ex. 17 indicates that the Dexter Corporation did establish an ERISA plan; however, the life insurance policy purchased from Northwestern was not part of it. Pages E. 82-83a, cited by Northwestern, are decidedly *not* to the claim procedure involving life insurance but rather to medical and dental benefits available to Dexter employees, which was part of an ERISA plan.[4] As to the medical and dental benefits Dexter set forth a right of review, as is required by ERISA. See 29 CFR § 2560.503-1(g). (A. 214).

In stark contrast the excerpt from the "STATEMENT OF BENEFITS AND POLICIES" dealing with the Northwestern life insurance policy (E. 57-63) contains no "statement of ERISA rights" or right of review as required by ERISA. (Compare E. 62a - 62 with E. 82a - 83). The portion of the STATEMENT OF BENEFITS AND POLICIES dealing with life insurance merely states, as is usually required, that written notice of claim be provided and that proof of loss be submitted. (E. 61a - 62).

Conclusion

Paul did not die as a result of natural causes. Even Northwestern no longer asserts that he took his own life. The Court should order that in failing to pay accidental death benefits Northwestern violated its obligations

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[4] Dexter contracted with Northwestern to provide the medical and dental benefits. (E. 64-83a).

under ERISA and that Mary Jane is entitled to the accidental death benefit, plus prejudgment interest and reasonable attorney's fees and costs. In the alternative, this Court should reverse the order allowing the motion to dismiss the contract claim and order a trial on the merits before a jury.

By her attorneys,

/s/ Richard L. Neumeier
Richard L. Neumeier
PARKER, COULTER, DALEY
& WHITE
One Beacon Street
Boston, MA 02108
(617) 723-4500